The role for marketing in public health change programs

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ABSTRACT

The public health paradigm provides a comprehensive framework for identifying target groups for action, setting objectives, identifying factors that influence risky behaviours, and generating policies to facilitate positive changes. What a public health approach lacks is a framework for the implementation of programs, and particularly with respect to communicating with and persuading target audiences to adopt recommended behaviours. This paper proposes that the discipline of marketing not only brings an innovative mindset to program planning, but also provides the means for effectively operationalising the conceptual frameworks and goals of health promotion and public health. Marketing not only includes an ecological perspective, but draws heavily from the social sciences with respect to models of attitude and behaviour change. This paper proposes that social marketing in the health area is the integration of marketing, the public health paradigm and the health promotion Ottawa Charter. This is illustrated by reference to a 'new 4Ps' that complement marketing's traditional '4Ps' and target upstream environmental and commercial marketing factors.

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Introduction

The public health paradigm and the principles of health promotion together provide a powerful and comprehensive framework for identifying the risk factors and risky behaviours that influence the prevalence and incidence of disease, identifying target groups most at risk, setting intervention objectives, and generating policies that facilitate positive individual changes through changes in physical and social environments.

However, what has been lacking in a public health approach has been a framework for the implementation of these planned programs, and particularly with respect to communicating with and persuading target audiences to adopt recommended behaviours, including individuals who make policy decisions. This paper proposes that the principles and tools of the discipline of marketing not only bring an innovative mindset to program planning, but also provide the framework and tools for effectively operationalising and actualising the conceptual frameworks and goals of health promotion and public health. Marketing is an appropriate discipline for this purpose as it not only includes an ecological perspective, but draws heavily from the social sciences with respect to communication, persuasion and models of attitude and behaviour change. Furthermore, at least in its ideal adoption, it relies heavily on research in its development of strategies to achieve measurable objectives.

Marketing and social marketing

Social marketing was first defined by Kotler and Zaltman (1971) as 'the design, implementation and control of programs calculated to influence the acceptability of social ideas and involving considerations of product, planning, pricing, communications and market research'. They referred to social marketing as simply the application of the principles and tools of marketing to achieve *socially* desirable goals, that is, benefits for society as a whole, rather than for profit or other organisational goals. It is this goal of societal wellbeing that distinguishes social marketing from all other marketing applications and defines what is and what is not *social* marketing. The adoption of marketing principles and tools in health promotion in Australia is well-established, beginning with the early tobacco control campaigns in the 1970s and 1980s.

Marketing is characterised by features such as a consumer orientation, segmentation and targeting, competitor analyses, extensive research with customers and potential customers to ensure that offerings are believable, relevant and motivating, and marketing plans for the '4Ps' of the marketing mix: Product; Place (distribution); Promotion; and Price. Research and negotiations are also undertaken with intermediaries such as retailers, and with stakeholders such as unions and

government, to ensure that making the product attractive, available and affordable will be facilitated by distributors and not hampered by structural and regulatory restrictions. In all these areas, the notion of an exchange process between the 'buyer' (target) and the 'seller' (marketer) forms a platform of operation. A necessary (but not sufficient) condition for a successful exchange is that marketers offer people something they value in exchange for them purchasing, stocking or recommending the product or adopting the desired behaviour, whether they be end consumers, intermediaries or legislators. 'What's in it for me?' is a key driver in determining appropriate incentives for the various target groups in campaigns.

Social marketing is just one 'branch' of marketing, where the branches reflect the area of application, for example sports marketing, business to business or industrial marketing, not-for-profit marketing, religious marketing, political marketing, and so on. However, the key point of difference to all other branches of marketing, is that the social marketer's goal relates to the wellbeing of the community, whereas for all others, the marketer's goal relates to the wellbeing of the marketer (that is, sales and profits; members and donations; political representation; etcetera). If the wellbeing of the community is not the goal, then it isn't social marketing.

Marketing draws on a number of disciplines for developing, planning and implementing marketing activities, but primarily psychology (for example, consumer decision making; attitudes, values); communication (especially for persuasion); economics (for example, utilities, price elasticity); and sociology (for example, behaviour of groups and organisations; diffusion). Social marketing extends marketing's borrowings from psychology (for example, mental health and happiness), sociology (for example, war and conflict, social movements) and economics (for example, globalisation effects), and further draws on disciplines and concepts that are related to community wellbeing, such as public health and health promotion, criminology, social policy and social welfare, and environmental sustainability. However, regardless of these elaborations, and regardless of whether we are targeting individual consumers or those in power to make regulatory changes, the primary paradigm is that of marketing.

Just like any marketing campaign, a social marketing campaign works when it's based on good research, good planning, relevant attitudinal and behavioural models of change, when all elements of the marketing mix are integrated, and when the sociocultural, legislative and structural environments facilitate (or at least don't inhibit) target audience members from responding to the campaign. A well-planned social marketing campaign stimulates people's motivations to respond, removes barriers to responding, provides them with the opportunity to respond, and, where relevant, the skills and means to respond. Where social marketing campaigns have

failed, it is not because the marketing paradigm has been inappropriate, but rather, the application has been inadequate or incomplete (see Gordon et al. 2006).

Some critics of social marketing campaigns have claimed that marketing's focus on the individual largely ignores the social, economic and environmental factors that influence individual health behaviours. While some social marketing campaigns deserve this criticism, this is not an inherent characteristic of marketing. One of the fundamental aspects of marketing—and hence *social* marketing—is an awareness of the total environment in which the organisation operates and how this environment influences or can itself be influenced to enhance the marketing activities of the company or health agency (Andreasen 2006; Buchanan, Reddy & Hossain 1994; Hastings & Haywood 1994).

Social marketing campaigns have been developed and implemented across a broad variety of areas, beginning largely in developing countries and dealing with issues such as rat control and other hygiene/sanitation areas, vaccination, family planning, agricultural methods and attitudes towards women (Manoff 1985). Applications in developed countries include a variety of areas although the majority and most visible have been and continue to be in lifestyle factors related to health and injury prevention (that is, tobacco, alcohol, drugs, nutrition and road safety), with lesser applications in other areas impacting on health and wellbeing such as 'problem' gambling, racism, child abuse and intimate partner violence, and growing interest in applications to energy conservation, recycling and climate control issues (Donovan & Henley 2010).

Social marketing in the health area (as already practiced by many health organisations), can be viewed as marketing being used to increase the effectiveness of public health and health promotion programs by providing principles and tools that more effectively reach and impact the target audiences for such programs. The aim of this paper is to provide an overview of a framework for integrating marketing, the public health paradigm and health promotion concepts for achieving socially desirable outcomes in any area, but with particular reference to health and wellbeing objectives.

Social marketing in action

There are numerous examples from Australia and around the globe of public health campaigns benefiting from a marketing approach (see Cheng, Kotler & Lee 2010; French et al. 2010; Hornik 2002; Horsfall et al. 2010). Australia's road safety, sun protection and tobacco control programs are prime examples of incorporating marketing principles and tools to enhance success. These have all been substantially

resourced, longstanding interventions. However, the following example shows the benefits of a marketing approach even at a small scale.

Mindful of dental injuries suffered in contact sports, Healthway (the Western Australian government-funded Health Promotion Foundation) provided sponsorship funds to Sports Medicine Australia in return for promoting mouthguard usage amongst junior basketballers and rugby players. The campaign encouraged juniors to wear a mouthguard, but not just any mouthguard, rather a higher priced, custom fitted one that delivered optimal protection. The objective was for players to wear these not only in competition, but also at training where usage was much lower.

In co-operation with dental professionals and their professional associations, a discounted price was offered to junior players for a set time. Dental professionals were recruited to visit the clubs and talk to coaches (influencers), players (users) and parents (buyers). The mouthguards were made available in attractive colours and designs (product attributes), and attractive posters with the 'Play hard. Get a Guard' logo (campaign brand) were displayed prominently in club areas. Coaches were enlisted to promote the benefits of mouthguards for the players (that is, avoidance of pain and risk of disfigurement), while dental professionals (expert sources) stressed the benefit to parents of avoiding major dental bills.

Compared with junior footballers who served as the comparison control group, mouthguard usage increased substantially in competition and at training for both rugby and basketball players. Usage during rugby training increased from 29 per cent at the beginning of the season to 40 per cent at the end of the season, whilst basketball training usage increased from 11 per cent to 30 per cent. In-competition usage went from 77 per cent to 84 per cent and 23 per cent to 40 per cent for rugby and basketball respectively (Jalleh et al. 2001).

The campaign was effective because it followed a number of marketing principles: all relevant groups were targeted simultaneously: coaches (influencers—their duty of care); players (the users, the product looked 'cool'—not 'daggy'); and parents (the purchasers, avoid high dental bills; parental protector). Inhibitors to purchase were addressed (discount price), promotional materials at the games kept the issue salient, expert sources were used to convince players and parents of the orofacial injury risks and consequences, access to dental professionals was made easy, and there was good co-operation between relevant stakeholders in the total sporting environment (that is, club officials, sport development officers, coaches and professional dental associations).

Health promotion

Given the involvement of various individuals with a marketing background in early Australian health promotion campaigns, health promotion can be viewed as an early adoption of a marketing approach to achieving desired lifestyle changes (for example, Egger, Spark & Donovan 2005). Health promotion has been described as a more proactive stance than 'health education', in that whereas health education attempted to inform people—and then left them to make a so-called 'informed choice'—health promotion attempts to not only inform but also to persuade people to cease unhealthy behaviours and to adopt healthy behaviours. Health education focused on biomedical information, risk factors and diseases in a fairly dispassionate format, and mainly in community and institutional settings, whereas health promotion includes highly graphic, emotion-arousing appeals, disseminated through mass media, to dissuade people from unhealthy habits (such as smoking). That is, health promotion has far more of a consumer orientation than did health education.

Back in 1986 the Ottawa Charter explicitly stated that health promotion should not only target individual undesirable behaviours but act to create social, political, health-service and legislative environments that support communities and individuals to make desirable changes. However, almost all early health promotion campaigns—and even more recent ones—largely targeted individual risk behaviours with little attention to the environments in which health promotion takes place (for example, schools; workplaces; cities; etcetera). Hence it is useful to recall the following pledge that signatories to the Ottawa Charter (1986) made:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;

- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;

- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;

- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;

- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;

- to recognise health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

Although the emphasis remains on the individual in some campaigns (such as the Commonwealth's Measure Up campaign), most health promotion programs are including these 'upstream' objectives in their programs, particularly as the health promotion approach is being increasingly accepted as more effective than the traditional health education approach by public health professionals who bring a broader, upstream perspective to such programs. This paper proposes that marketing principles can be used to help focus on these upstream objectives as well as downstream individual objectives.

The public health approach

A common call today by health and social policy professionals is for 'a public health approach' to almost every health and social ill, from the obesity problem, violence, adolescent substance use and increasing physical activity, to reducing medical malpractice errors (Google Scholar 'public health approach'). Much of this has arisen from the success of the public health approach in controlling infectious diseases (and environmental hazards) and applying the same principles and methods to lifestyle behaviours such as tobacco use (in conjunction with health promotion).

Public health is concerned with preserving, promoting and improving health, with an emphasis on prevention and at three levels: primary prevention—preventing problems occurring in the first place (universal interventions); secondary prevention—targeting at-risk groups before the problem is established (selective interventions); and tertiary prevention—attempting to prevent the problem reoccurring (indicated interventions). Hence relationship programs for young males in general about respecting women are an example of primary prevention; interventions aimed at young males whose father or male carer was abusive represent secondary prevention; behaviour-change programs for men who have emotionally or physically abused their partner represent tertiary intervention.

The steps in a public-health approach can be described as follows:

1. Determine what is the problem via systematic data collection ('surveillance') (for example, extent and nature of violence against women; prevalence of

substance use among tweens and teens). This is particularly important for setting relevant goals, including behavioural objectives.

2. Identify risk and protective factors via epidemiological analyses and attempt to identify causes (by experimental and other methods) and other effects in various groups. Such analyses are particularly important for target audience identification.

3. Develop and implement interventions to see what works, why and for which groups.

4. Apply the efficacious interventions population-wide, assess their impact and cost-effectiveness.

5. Continue surveillance, data analyses and modification of interventions.

Social medicine

A public health approach incorporates an acknowledgement of all environmental influences on health and welfare, and, from its beginnings as 'social medicine' in Europe, social inequalities in particular. This is epitomised in Virchow's famous statement that social conditions influence health, and hence political action is necessary to restructure society and remove these social conditions. Virchow stated 160 years ago that 'medicine is a social science and politics nothing more than medicine on a grand scale'. Virchow meant that a society's health is very much dependent on the way that society structures itself. Factors affecting the health of populations may be different to those affecting the health of individuals. While the health care system deals with the proximate 'causes' of illness, broader social changes are necessary to deal with population causes (Mackenbach 2009).

Social medicine is most associated in the twentieth century with South America, and with names like Salvador Allende (the military-CIA deposed Chilean leader) and Ernesto 'Che' Guevara (Waitzkin et al. 2001) (see the movie 'Motorcycle Diaries' for Guevara's 'discovery' of the relationship between poverty and ill-health).

Social marketing: Facilitating health promotion and public health

An often cited definition of social marketing in the past decade has been Andreasen's (1995): 'Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society.'

From a health promotion/public health perspective this definition is unduly constrictive in its apparent emphasis on *voluntary* behaviour change of individuals' unhealthy or risky behaviours and *individuals' own welfare*. For example, a social marketing campaign with an end goal of individuals consuming less saturated fat might also target biscuit manufacturers to persuade them to replace saturated fats in their products with polyunsaturated fats. While this requires a voluntary behaviour change among the food company executives, the end-consumers' change in saturated fats intake is involuntary. Furthermore, from Donovan and Henley's (2010) point of view, lobbying legislators to enforce such substitutions (that is, individual voluntary behaviour by legislators; involuntary by food manufacturers and their consumers), would also be part of a comprehensive social marketing program.

Donovan and Henley (2010) first modify Andreasen's definition by adding 'involuntary' and second by expanding it to include those who make decisions that affect the welfare of others: 'Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary or involuntary behaviour of target audiences in order to improve the welfare of individuals and society.' In fact this definition is more in keeping with Andreasen's (2006) upstream emphasis.

Donovan and Henley further extend this definition to accommodate two key points underlying their approach to social marketing:

- First, much of the debate about defining social marketing and the common good centres on how to establish this so-called 'common good' in pluralistic societies (that is, 'who decides what is 'good'?') While this is rarely an issue in practice, they propose the UN Universal Declaration of Human Rights as the baseline with respect to the common good.

- Second, most social marketing to date, particularly in the health and injury prevention areas, has focused on achieving individual behaviour change, largely independent of the individual's social and economic circumstances. Since Virchov's observations in the nineteenth century, overwhelming evidence has cumulated with respect to the various social determinants that influence health over and above individual behavioural risk factors and physical environment risk factors (Wilkinson & Marmot 2003). These social determinants result from the social structure of society in (interrelated) areas such as the workplace, education, literacy and community cohesion. Hence a primary goal of social marketing is to achieve changes in these social determinants of health and wellbeing.

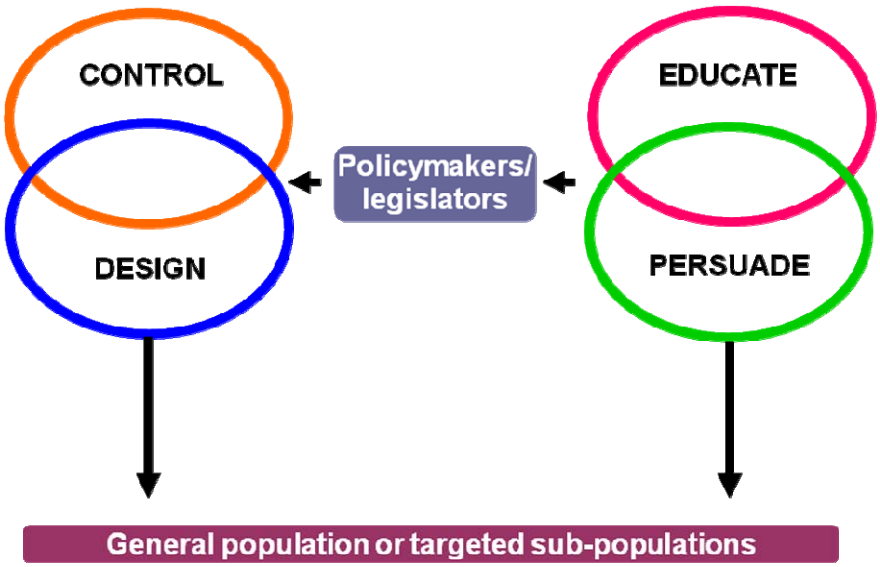
That is, for Donovan and Henley (2010), the domain of social marketing is not just the targeting of individual voluntary behaviour change and changes to the environment that facilitate such changes, but the targeting of changes in social structures that will facilitate individuals reaching their potential. This means ensuring individuals' access to health services, housing, education, transport and other basic human rights that clearly impact on health status (Gruskin, Plafker & Smith-Estelle, 2001). This requires the targeting of individuals in communities who have the power to make institutional policy and legislative change (Andreasen 2006; Hastings, MacFadyen & Anderson 2000).

Towards a comprehensive framework for social marketing

Various authors have proposed various primary methods for achieving individual behaviour change and hence social change. Rothschild (1999) has proposed education, marketing (persuasion) and the law (regulation); Donovan and Henley (2010) have proposed education (information and skills), motivation (persuasion) and advocacy (for socio-political action); whilst the UK's National Centre for Social Marketing (NSMC) proposes education, persuasion, control (legislation; regulation) and design (environmental interventions). Clearly there is considerable overlap in these perspectives. In Donovan and Henley's perspective, advocacy is to bring about changes in regulation as well as changes in the physical environment that facilitate adoption or expression of desired behaviours and inhibition or elimination of the opportunity for undesired behaviours—what has been called 'choice architecture' by Thaler and Sunstein (2008).

The UK model represents a good overall summary of the major ways for bringing about changes in undesirable behaviours at the individual level. Adding Donovan and Henley's advocacy component reminds us that achieving regulation and environmental design changes also requires education and persuasion interventions that target policy makers and regulators, as in Figure 1.

Figure 1. Social marketing framework*



* Adapted from a Figure developed by Rob Donovan, Mark Francas, Global Deputy Head, TNS Political and Social Research and Donna van Bueren, Director TNS Social Research Australia.

Are education, advocacy and regulation really part of marketing – and hence social marketing?

Some readers might question whether these strategies are part of marketing. I argue elsewhere (Donovan 2011) that although they are indeed separate disciplines, they are used to varying degrees by various marketers to achieve their goals. For example, marketers negotiate exclusive merchandising rights to sponsored events and lobby governments to legislate to protect their sponsorship rights. For example, Australia introduced laws prior to the 2000 Olympics to protect official sponsors from 'ambush' marketing, and at the World Cup in South Africa several young women acting on behalf of Bavarian beer who 'ambushed' the official Budweiser sponsor were arrested by the Police (Evans 2010).

With respect to advocacy, Kotler proposed that public relations to manage a company's 'publics' (including government) 'should be conceived of as a broad marketing operation rather than a narrow communication operation' (Kotler 1980, p. 51), and he called lobbying 'essentially company marketing in the arena of the legislative market' (Kotler 1980, p. 52).

Furthermore, many of the activities used by public health and climate change 'activists' are similar to the activities used by companies who adopted the strategies

of 'marketing warfare', a concept which peaked in the 1980s (Kotler & Singh 1981; Ries & Trout 1986). I have elsewhere suggested marketing warfare as a useful metaphor for going upstream (that is, 'social marketing warfare') (Donovan 2010). In fact, the warfare metaphor may be receiving renewed attention in marketing (see Kolar & Toporišic 2007).

With respect to education in marketing, pharmaceutical and industrial/technology marketing are just two areas where education plays a substantial if not dominant role in marketing plans. For example, the pharmaceutical companies sponsor extensive education of GPs, specialists and pharmacists with respect to their drugs; company sponsored clinical trials are published in medical journals and distributed by the sales force to doctors in face-to-face meetings (Blech 2006; Petersen 2008).

Social marketing's 'new 4Ps'

In addition to commercial marketing's basic 4Ps (Price; Place; Promotion; Product), applying marketing to the concepts of health promotion and public health suggests a new additional 4Ps for social marketing. These additional new '4Ps' represent the goals of social marketing in the context of health promotion's Ottawa Charter, the public health approach and the need for change at a societal political level (see Maibach, Abroms & Marosits (2007) and Cohen, Scribner & Farley (2000) for similar but more limited frameworks). Hence, these 4Ps emphasise the need to modify environmental influences on behaviour along with upstream social determinants factors. Furthermore, tools such as advocacy and activism are more prominent—but do not replace—marketing's more mainstream methods.

These 4P goals are to achieve changes in:

- **population** prevalence of individual undesirable, unhealthy or risky behaviours (for example, smoking rates; physical activity; incidence of child abuse; etcetera)

- the design and/or marketing of **products** people use or consume that impact on health and wellbeing (for example, healthier food products; restrictions on alcohol marketing; pre-set limits on gambling machines)

- the design and/or marketing of **places** where people live, work and play so as to reduce harm and enhance wellbeing (for example, safer children's playgrounds; automatic teller machines banned from gambling venues) and

- the **political** structure that allocates resources so as to ensure increased equality of access and opportunity in society (for example, increased allocation to education rather than elite sport).

Marketing per se and Hastings, MacFadyen & Anderson (2000) in their going upstream essay remind us that to achieve such changes we are always targeting individuals, and hence must always take into account the appropriate way to communicate with those individuals and to offer them something of value in return for them adopting our recommended behaviour. A good example of the exchange process in action—albeit largely independent of public health advocates—was independent candidate Andrew Wilkie's agreement to support the Gillard government in return for mandatory 24-hour pre-set limits on poker machines. This is also a good example of opposition to upstream product interventions. There are already reports in the press that in the face of intense lobbying by ClubsAustralia on behalf of gambling venues, the government may renege on the agreement (Saluszinsky 2010).

A comprehensive 'new 4Ps' social marketing program targets …

> *individuals* to encourage them to change their unhealthy and undesirable beliefs, attitudes and behaviours so as to achieve **p**opulation prevalence changes (for example, targeting men who use violence against their partner to seek help, householders to reduce electricity use; changing racist or gender or mental illness stereotypes; etcetera);
>
> *individuals* with either the power to influence the manufacture and marketing of consumer and industrial **p**roducts and services or their regulation so as to eliminate, modify or restrict access to unhealthy and undesirable products and promote the development and marketing of healthy alternatives (for example, regulation of 'sin' products, including guns; making motor vehicles safer in collisions; safer toys; stricter building regulations; low-alcohol/fat/sugar/salt alternatives; mandatory additives in some products; carbon emission reduction technology; slower operating poker machines; etcetera);
>
> *individuals* with the power to make changes to and regulate activities in **p**laces where people congregate (for example, work sites; schools; recreational areas; institutions/hospitals; sporting venues; etcetera) so as to facilitate healthy, positive behaviours and reduce risky behaviours (for example, safe exercise areas; safe serving practices in bars; regulations to prevent overcrowding; shade sails over swimming pools; reduction of lead emissions; safe rail crossings; canteens with healthy foods; no-smoking areas; urban design to reduce crime; etcetera);
>
> *individuals* who have **p**olitical power to determine the allocation of a society's financial and other resources and to change public institutions

> such as the media and the law, and government bureaucracies such as education and health services, so as to ensure equality of access and opportunity as per the Universal Declaration of Human Rights.

It is in this last area that public health professionals and social marketers need to co-operate with and learn lessons from social medicine, liberation theology, civil rights movements, legal activists and others (see Ackerman & DuVall 2001).

Consider a national strategy that aims to create a more favourable environment in Australia so as to reduce and prevent harm to children and to facilitate optimising their potential. Following the new 4Ps approach, a comprehensive social marketing program would aim to achieve the following goals:

> **Population** changes in individuals who have children in their immediate care, such as parents, teachers, coaches, youth workers, etcetera, so as to ensure that the way they dealt with children enhanced rather than damaged their well being (for example, promoting positive parenting; encouraging teachers to allow children's participation in decisions that affected them at school; encouraging attendance in rehabilitation programs for those who abuse or neglect children in their care; etcetera)
>
> **Product** and service changes by targeting individuals who are responsible for the manufacture and/or marketing of products that may negatively impact on children, and the individuals with power to regulate same (for example, alcohol marketers to not market to children either deliberately or inadvertently; safe toys; adequate restraints in vehicles; enhanced educational products for children; advertising and marketing controls in general; healthy food products in school canteens; etcetera)
>
> **Place** changes by targeting individuals with the power to make changes to and regulate activities in places where children congregate (for example, shade in school yards and public swimming pools; safe playgrounds—surfaces and equipment; urban designs that encourage children's physical and social activity; etcetera)
>
> **Political** changes by targeting individuals with power to ensure a greater allocation of resources to protect children and to provide opportunities for learning and wellbeing (for example, education, health and sport/arts ministers; party policy writers/advisors; premiers and prime minister; senior bureaucrats; changes in areas such as increased training and remuneration for child workers and primary school teachers; increased allocation to remedial programs and disadvantaged schools; etcetera)

Overall, coupling the traditional marketing framework with the new 4Ps framework is more likely to result in a comprehensive program, and hence a greater likelihood of sustained effectiveness. This applies not only to the health area, but to all areas of application where the objective is the social good.

Concluding comments

Social marketing can be viewed at one level as simply a bag of tools or technologies adapted from commercial marketing and applied to issues for the social good. A key point is the marketing concept or 'philosophy' that emphasises the perspective of the target audience as the basis for achieving mutually satisfying exchanges. From a broader perspective, social marketing in the health area is the application of commercial marketing techniques in the context of the Ottawa Charter and the public health paradigm, so as to achieve individual behaviour changes and societal structural changes consistent with the UN Universal Declaration of Human Rights.

However, the US National Academy of Sciences' Institute of Medicine (2000) report into social and behavioural intervention strategies for health concluded that although environment based strategies have greatest population effect, far more progress had been made in developing individual oriented interventions than environmental oriented interventions. The new 4Ps are a way to help redress this situation. It is noted that Australia's National Preventative Health Taskforce chaired by Rob Moodie has recommended social marketing strategies be adopted for the three main areas identified for action in Australia (obesity, alcohol, tobacco) (National Preventative Health Taskforce 2009). The new 4Ps are consistent with various aspects of the Taskforce's recommendations, including the emphasis on engaging communities (changes in places) and influencing markets (changes in products and their regulation). The Australian Taskforce also noted the need to reduce inequalities that influenced the three main action areas. However, to achieve this turnaround (changes in political priorities), future applications of social marketing will need to work alongside practitioners in, and incorporate lessons and principles from, areas such as social medicine, social activism, social entrepreneurship and civic engagement.

This paper argues that government health policy and implementation would benefit from a stronger emphasis on the adoption of the social marketing principles and frameworks advocated in this paper with respect to achieving structural change. However, the danger is that the focus would remain on individual responsibility as the UK government's initial embrace of social marketing did in the health domain. Implementations of new 4Ps strategies will be facilitated where corporate and political interests are not affected or are enhanced by such strategies—for example universal immunisation is supported by both government and the pharmaceutical

industry, and road safety initiatives are supported by both government and the insurance industry.

However, other areas are less politically attractive and resisted strongly by vested commercial or ideological interests—such as the abolition of slavery, violence against women in patriarchal societies, and the campaign against 'big tobacco'. That is, the major impediments to achieving upstream change will come from industries' resistance to any changes they believe will impinge on their profit-making capacity, and the vulnerability of governments and other regulators to these industries' persuasive arguments and donations, along with government's own self-interests. The gambling industry is a classic case in point, especially in NSW, where all attempts to control poker machine operations are countered by massive political donations and subsequent inaction by government (Klan 2010).

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